"New" and distributed leadership in quality and safety in healthcare, or "old" and hierarchical? An interview study with strategic stakeholders

SHORT TITLE: Leadership for quality and safety: interview study

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Abstract

Objectives: We aimed to explore the views of strategic-level stakeholders on leadership for quality and safety in the NHS.

Methods: We interviewed 107 stakeholders with close involvement with quality and safety as professionals, managers, policy makers or commentators. Analysis was based on the constant comparative method.

Results: Participants identified the crucial role of leadership in ensuring safe, high quality care. Consistent with the academic literature, participants distinguished between traditional hierarchical "concentrated" leadership associated with particular positions, and distributed leadership involving those with particular skills and abilities across multiple institutional levels. They clearly and explicitly saw a role for distributed leadership, emphasising that all staff had responsibility for leading on patient safety and quality. They described the particular value of leadership coalitions between managers and clinicians. However, concern was expressed that distributed leadership could mean confusion about who was in charge, and that at national level it risked creating a vacuum of authority, mixed messages, and conflicting expectations and demands. Participants also argued that at, hierarchically based leadership was needed to complement distributed leadership, not least to provide focus, practical support and expertise, and managerial clout.

Conclusions: Strategic-level stakeholders see the most effective form of leadership for quality and safety as one that blends distributed and concentrated leadership.

Policy and academic prescriptions about leadership may benefit from the sophisticated and pragmatic know-how of insiders who work in organisations that remain permeated by traditional structures, cleavages and power relationships.

Introduction

Despite sustained effort over the last decade, health systems worldwide, including the UK National Health Service (NHS), are faced with evidence of serious deficits in the quality and safety of care delivered to patients.[1] Investigations into high profile failures – including those of Mid-Staffordshire NHS trust - have repeatedly emphasised the importance of leadership in securing and improving quality and safety.[2] It is one thing to identify the importance of leadership; it is quite another to achieve clarity and consensus on the ideal forms of leadership and to put them into practice.[3][4,5] The academic literature on leadership is extensive, but different studies use different definitions that may compete, conflict, or overlap (for example in the way they distinguish management from leadership)[4] and many terms are used loosely or in different ways in different contexts.[6] The field is further complicated by lack of a high quality evidence base.[7]

Despite the fierceness with which some of the debates in the academic literature are fought, remarkably little is known is about the views of those in senior positions in relation to quality and safety the NHS on the precise form leadership for improvement in healthcare should take, who the leaders should be, and how they should enact their leadership role, nor is it clear the extent to which their views conform to or contest the features of academic debates. This is not a trivial problem of interest only to scholarship, but one with real practical implications. Clarity about leadership in an era of large-scale institutional reform and associated uncertainties

has important implications for who commits to leading quality and safety, how direction is set, and what gets prioritised by whom. In this article, we report an empirical study of the views of stakeholders in senior positions. We explore how they talk about leadership for quality and safety, including how far their views align with or oppose prominent debates in the academic literature.

We begin by outlining some of these debates, including the tension between "old leadership" and "new leadership". Old leadership is typically constructed as the heroic acts of single individuals usually in powerful positions at the tops of organisations, who exercise skillful and creative managerial techniques.[8] Newer conceptualisations of leadership, by contrast, see leadership as a property shared by multiple individuals, who may or may not be positioned at the top of a hierarchy.[8] Here, leadership is not a direct product of positional authority or use of particular methods, but rather of skills, character traits and relationships that can be deployed contingently by a breadth of individuals, depending on the task in hand.[9] Leadership may thus be 'distributed' through multiple levels of organisations rather than hierarchically 'concentrated' in a small number of hands. Distributed leadership is achieved through a wide variety of individuals, and is conceptualised in terms of the act of leading rather than role positioning.[3, 10]

New and distributed leadership is claimed to have several advantages in the pursuit of improvement, especially in public service fields characterised by complex problems that cross the boundaries of organisational responsibility, multiple professional groups with divergent identities, norms and accountabilities, and ambiguous or multifaceted aims.[11] An overreliance on older, concentrated leadership is argued to limit the scope and impact of efforts to lead, perhaps by

failing to cross institutionalised boundaries between professions, clinical areas and organisational units.[12] This can be especially problematic in fields such as quality and safety, where improvement relies crucially on the conjoint effort of multiple parties separated by such boundaries.[13, 14] Thus, an influential account argues that efforts at improvement in healthcare are especially prone to failure when they rely too heavily on old leadership rather than recognising, valuing, and mobilising new forms of leadership that are distributed throughout organisations.[8, 15-19]

The reasons why leadership may need to be distributed across multiple groups and multiple levels lie in the range of stakeholder groups, both professional and managerial, who occupy the institutional territory of healthcare and have a stake in issues of quality and safety.[20] All may have an important role to play in modern, multidisciplinary healthcare organisations.[14] However, distributing leadership in order to improve quality and safety is far from straightforward. Different professional and managerial groups often endure an uneasy co-existence, their interests competing amid messy power relations.[10, 15] Unless carefully managed, distributed leadership may give rise to a 'nobody in charge' model[10] or the mere re-badging of activities and roles as leadership. Either may result in the dissonance and disenfranchisement of those drawn into leadership, but without possessing any power to lead.[3]

Given the risks of a descent into disorganized and rivalrous tensions or inauthentic rebranding exercises, how far it may be possible to distribute leadership in order to engage, value, and give respect to the contributions of those who seek to secure patient safety and quality of care is not clear. However, few studies have invited people closely engaged with health care delivery in the UK to talk directly about their

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interpretations of leadership in relation to quality. As Jackson and Parry[21] point out, "everyone wants to talk about leadership", but less is known about what is being said and interpreted and what implicit models of leadership are current or potent. Leadership may be a pervasive discourse among policy makers,[3] but how far the notions of new, 'post-heroic' or distributed leadership have salience among those involved in managing and delivering services is unknown.[21] Indeed, some studies identify a discernible gap between normative notions of leadership and roles as they are enacted.[22] These are important and current problems, given that remedial prescriptions for leadership as the solution to problems of quality and safety are often vague and aspirational, and have been criticised for failing to take account of contextual contingencies and institutionalised constraints on the possibility of leadership. [22] [23]

In this article, we take the view that "talk" about leadership among those given the mantle has been under-described, even though the accounts of people charged with improving quality may allow a more realistic picture of the possibilities and limitations of leadership to emerge. We sought to investigate, through a large-scale interview study, how strategic-level stakeholders across the NHS talk about leadership, including, in particular, the extent to which such talk reflects or contests the ideas that feature in the academic debates around old, new, concentrated and distributed leadership.

Methods

This study was conducted as part of a large multi-level, mixed-method research project funded by the Policy Research Programme for the UK Department of Health. For this study, interviews were conducted with 107 NHS stakeholders in England

and Wales and other experts across the UK with a strategic-level interest in patient safety and quality of care. Individuals were purposively sampled from public sources (including websites and conference brochures) and through extensive snowballing. All were selected as a result of close involvement in quality and safety either through their posts, specific initiatives - either local or national - or through their involvement in research and commentary. We asked respondents questions about aspects of delivering quality and safety improvement in healthcare, including what they understood a vision of the delivery of high quality, safe care to comprise; what was required to make it happen; and what theories of change and quality improvement they are deploying. We also asked about how improvements could be secured and what stands in the way. Though issues of leadership permeated many responses, two specific questions honed in on leadership and governance: first, who was leading the initiative for quality and safety in the NHS and second, who should be doing so?

Table 1: Participant Profile

Stakeholder Role	Number of Participants	%
Managers who were also Clinicians	47	44
Managers	18	17
Clinicians	15	14
Commentator (e.g. from academic and charity sectors)	13	12
Commissioner	7	7
Manager/Commentator	4	3

Commentator/Clinician	3	3
Total	107	100

An interview topic guide was developed through literature review and discussions within the project team, and was customised to capture the diverse stakeholders. We grouped participants broadly into stakeholder types (Table 1) though many had composite roles. Interview participants included senior NHS executives, for example chief executives, medical and nursing directors, executive and non-executive directors ,trust chairs, front-line staff, clinical directors, directors of clinical governance, Strategic Health Authority managers, quality and patient safety managers, and NHS commissioners. We also interviewed individuals from UK public and independent policy bodies and senior university health care researchers (described here as commentators). NHS respondents came from across England and a range of trusts. Many held combined positions as clinician-managers. Several who were involved in commissioning had also had lengthy clinical careers and some academics had held NHS posts. All the commentators had specific research knowledge of quality, patient safety and health care management. Interviews took place over a period of 12 months from January until December 2011.

Interviews were transcribed verbatim. Analysis was based on the constant comparative method.[24] We worked collaboratively to agree an interpretative framework, making use of some sensitising concepts[25] drawn from the literature on leadership quality and safety to supplement our interpretations. We conducted close and systematic reading of the transcripts and independent coding by two researchers to extract themes and patterns of responses across all interviews–first,

following the order of the interview schedule and questions, and second, by reading within as well as across cases, to appreciate responses by each respondent as well as across the group. Given constraints of space, for this article the analysis is mainly at the broader level of typical or dominant aggregated thematic responses across all participants and is not further broken down by categories of respondents. Coding was supported by NVIVO 8 software.

Research ethics committee approval was received for this study. Participants' identities have been anonymised.

Findings

We discuss our findings in three sections. First, we give an overview of the accounts of leadership and its place in improving quality and safety given by participants, noting the primacy given to leadership and the value of working to distribute leadership. Second, we show that participants reported that spreading of leadership responsibilities at national level risked creating a vacuum of authority, leaving some confusion. Third, we suggest that enthusiasm for distributing leadership at organisational level was tempered, with participants arguing for the enduring importance of old, concentrated forms of leadership alongside newer forms.

Leadership at every level as essential to patient safety and quality

Leadership talk was pervasive in interviews: participants spoke at length about leaders and leading. The language and symbolism of leadership enjoyed considerable cultural orthodoxy, and was embraced as an important part of the solution to challenges of quality and safety in health services. Participants made little discrimination between leadership for quality (broadly defined) and leadership

for safety (defined as absence of avoidable harm); the two were coupled together in most conversations, though this may in part have been due to the framing of the issue in the topic guide.

One very important emphasis in many interviews was on a set of ideas that might be considered consistent with academic ideas on distributed leadership. Mirroring the theoretical rationale for 'new' leadership put forward in the academic literature on leadership in complex organisational settings summarised above, participants described the need for different organisations and individuals to share accountability for patient safety and quality In many responses was recognition of organisational and institutional complexity, the operation of multiple levels and complicated interactions and boundaries of responsibility.

'Well at some level, leadership is a dispersed quality, throughout the healthcare system. From our perspective we know, we work on a number of people at senior level who have responsibility, sorry, who are leaders themselves, who lead quality.' Commentator (KC010)

'Well I think there needs to be formal clinical leaders…. so clinical directors for example, and they need you know very good sort of management and leadership development. But I guess like in any organisation you need some informal leaders as well and they will emerge and it's a matter of making the most of those. Some are the formal leaders and some are, sort of, don't have a formal position but clearly have an influence in their clinical areas.' Commentator (KC011)

At the level of individual organisations, participants repeatedly stressed the need for leadership for quality and safety to exist among multiple professional stakeholder

groups, and emphasised that such leadership needed to cut across professional and organisational boundaries. Participants identified a variety of organisational actors as enacting such leadership roles. They included both those at the top of organisations and those in much less senior roles. Among those frequently cited as playing critical roles in leading safety and quality were chief executives, medical directors, chief nurses, organisational boards, matrons, clinicians, and those identified in named quality and safety managerial roles. But participants emphasised that leadership for quality and safety should not be left in the hands of a few, or devolved to specialists, but rather should be widespread and integral to everyone's remit. A particular role was noted for 'ordinary leaders'. These 'people on the ground' included nurses, junior and middle managers, doctors, or other health professionals, who were seen as vital to the leadership of quality and safety.

'I think on the quality team you need a balance of clinicians and non-clinicians to help make sure you get the best of both worlds if you like. It's the same with the provider executive team, they need the clinicians to keep the passion and a bit of sensible head on, but you need the non-clinicians to hold them to account and not be too lenient.' Non-Executive Director (KC009)

The need to imbue a sense of local ownership of the challenges of quality and safety was repeatedly stressed. Leadership, it was argued, needed to be enacted at the ground level, and embodied by local leaders with professional legitimacy, practical knowledge and local visibility. This ordinary leadership could, it was suggested, be the key to the influence and inspiration that could make improvement happen:

'I see matrons with X, if I am sitting in on matrons' meeting with her and she's there..

I think when I watch matrons who are new... we all get caught up with X's agenda for

this drive for quality'. Patient Safety Manager (JW 045)

Ordinary leadership encompassed leadership by example, acting as a role model, and turning day-to-day interactions with colleagues into opportunities for learning about good quality and safety practice that would improve routine practice:

'..that's about visible leadership, so that is what matrons need to do. It's great when

they are out there… if I saw a member of staff, I'd say 'hang on a minute what are

you doing with that? Where are you going with that drug? And say 'you are not going

to draw that up on the bedside locker, you know, no, actually I'll come and do it with

you.' So I would actually go through it with them.....I think having more visible

leadership out on the wards enables that to happen more.' Assistant Director of

Nursing (JW031)

In recognising the importance of distributing leadership across diverse constituencies, participants stressed that ordinary leaders could wield the influence necessary to tackle the complex, contextually specific problems of quality and safety, drawing on the particular opportunities for influence that they had in their professional and organisational positions (as in the quotation above). For some, this distribution of leadership extended to more-or-less everyone: *'it's in everybody's title ... we are all in it'*, as one put it, or in the words of another: *'well, aren't [we] all leaders, leading it; isn't that our day job?'* Many respondents gave examples of the multiplicity of people who could occupy leadership roles from board level to ward level, from blunt end to sharp end; from 'apex to floor'. However, the challenges of

distributing leadership for quality and safety different levels throughout the NHS recurred throughout our dataset.

Challenges of distributed leadership: national level

Despite the enthusiasm for distributed leadership evident in many accounts, excessive pluralisation of responsibility under the NHS reforms at national level was seen as running the risk of leaving "nobody in charge". Overall, there was a strong sense of organisational uncertainty and flux together with reported loss of focus on quality and safety. Lack of coherence, the proliferation of tiers and intersecting bodies and burgeoning of initiatives were seen as perplexing. Some respondents noted duplication of initiatives, an overload of those with a claim on leadership and a consequent attenuation of the importance of quality and safety:

'I think personally there are too many people leading it and I think there are too many initiatives coming down. If you look at something like the 'four harms', you have got so many different initiatives and they are all asking different things. You have got your high-impact interventions, you have got Safety Express, you have got NICE, you have got the Health Protection Agency, you have got the NPSA and everything. They are all perhaps giving guidance on similar things but slightly different guidance. And then you have to report in different ways on the same thing.' Clinical training and Development Nurse (JW 036).

Comments from diverse interviewees suggested a lack of clarity about who was 'in charge', a shifting 'top tier' of organisations, and individual and organisational leadership in turbulence:

'I don't think anybody is leading it to be honest, if you are talking about a single person.' Commissioner (JW19)

'I think at the moment there is a bit of a void from the Department of Health to be perfectly honest. In the sense of who leads on quality, I don't get a sense you know that there is this one person who is driving quality at that level.' Non-executive Director (KC 009)

'I think that's a very difficult question, I think the NHS has gone through so much transition. I think some of that leadership has gone.' Senior Nurse (JW056)

Challenges of distributed leadership: organisations

The enthusiasm for shared responsibility for patient safety and quality was further tempered by cautions about abandoning "old" leadership altogether. Participants suggested that while new leadership had its place in pluralising responsibility and engaging diverse stakeholder groups in the task of improvement, it risked diluting the importance of quality and safety, decentring leadership such that everybody's responsibility became no-one's. Participants recognised no easy answers around how to lead effectively for quality and safety, but they challenged some of the claims made for the value of new leadership on its own, suggesting instead that the most effective strategies involved combining old and new. Thus, many of the comments on the effectiveness of distributed leadership were nuanced, with references to the role of formal and informal power structures in health care.

The unique influence of powerful doctors was widely discussed, particularly in discussions of organisational hierarchy, clinical engagement and clinical resistance. Participants expressed strong beliefs about the need for cultural change and

frequently mentioned the need to achieve clinical 'buy-in' to quality and safety. They thus suggested that leaving responsibility entirely up to front-line clinicians was not enough on its own; it risked losing focus and inducing incoherence. Rather, they reported, forming productive coalitions and alliances between clinicians and managers to lead on quality and safety could be an effective way of combining credibility with control, and of signalling the organisational priority given to quality and safety.

'I'd say that's generally a shared thing between myself and the medical director' Quality Improvement Manager (JW028)

'We're lucky here yeah, we've got a really good balance. I mean our chief exec's an accountant so you know, he's got this very pragmatic view of the world. And then the clinicians around him put the, I won't say personality, but the personable nature into the view as well.' Quality manager/commissioner (JW019)

Many participants highlighted the leadership potential of those in senior, hybrid positions that combined the knowledge and professional legitimacy of clinical experience with the ability to make things happen—if necessary by coercive force— of managerial authority. Several, for example, highlighted the role of senior nurses in leading for quality:

'Oh it's mainly the drive of the chief nurse, simple as that. What (chief nurse) combines is a real passion for improving quality of care, combined with actual practical ability to do it.' Trust Chief Executive (JW002)

Thus, participants suggested that distributed leadership needed to be complemented by some elements of more old-fashioned hierarchical leadership. For instance, top-

level backing for what was happening on the ground was seen as essential. Without senior leadership support, the enthusiasm and will of those at the sharp end were seen as vulnerable to withering. However, participants were careful to stress that the *kind* of leadership provided by the senior team in organisations was critical. They framed the qualities needed in terms of authenticity. It was not enough for leaders to espouse the value of quality and safety; rather, senior leaders had to display and communicate commitment in their actions so as to achieve wider buy in and engagement.

'I do think you need top down because if you don't have that kind of drive, people further down the chain want out of it.' Consultant (KC003)

'I think that what sends the message about all patient safety and quality really is that the leadership does have to come from the top and it doesn't have to mean that they actually do any quality or safety initiative themselves, as in it's reported up….otherwise the staff on the shop floor who are doing it, they lose the will to carry on as it were.' Director of Nursing (JW031)

The complexity of health care systems, and the spread of power across broad managerial and professional groups, made the link between leadership and managerial authority more, not less, important. As one trust's head of patient safety put it:

'The chief exec, whoever has the executive lead for patient safety, you know, if that person is on a mission then it usually happens, assuming they stick around long enough for it to happen.' (JW046)

Furthermore, in response to the direct questions about leadership, participants tended not to discriminate very precisely between the functions of management and leadership. This was in (perhaps surprising) contrast to policy and academic conceptualisations of 'new' and 'ordinary' leadership, which clearly differentiate between the two. What was clear from participants' accounts was that making quality and safety a priority in health care, and sustaining interest, required not only senior managerial endorsement but also sound practical support.

'What is fundamentally important is the quality of the interpersonal skills of the leader. In other words, whilst it is always important to understand what quality improvement is at some level of technical proficiency, what is more fundamental are the interpersonal skills in trying to manage change, make organisations ready for change, dealing with resistance, those kinds of things.' Commentator (KC010)

'Now it's fine having the right sort of values but if you don't have a practical way of executing them it does not get you anywhere. You know it's all very well, I mean not being too funny about it, but our previous chief nurse, she had fabulous values, was extremely popular with frontline nurses, you know there was a complete institution, but she didn't have any systems in place to actually make things improve over time.' Trust Chief Executive (JW002)

In order for leadership to operate effectively, participants suggested, leaders required infrastructural administrative support and/or positional power to command influence and lead others. Having legitimacy and credibility with a range of local actors was one thing, but to ensure that improvement happened, it needed to be backed up by managerial authority:

'It is partly leadership by example [...] leadership itself can be a catalyst to get things started but you then need an infrastructure to support it.' Trust Chief Executive (KC006)

DISCUSSION

By listening to senior stakeholders' talk about leadership, we have been able to identify the implicit concepts and views of leadership that people in the NHS use to guide practice and make sense of reality in complex health care contexts. Our analysis shows that a shift to 'new' leadership needs, in the view of these stakeholders, to be balanced and complemented by direction-setting at a national and unit level; hierarchical approaches most commonly characterised as 'old' leadership are thus seen as having an enduring and useful role. We have also been able to assess how far these understandings are consistent with current academic debates around leadership for quality and safety in the NHS. We have identified participants' sophisticated arguments for combining the best aspects of old and new, concentrated and distributed leadership in ways that are situationally specific and contextually sensitive. Participants were clear and explicit that all staff in the NHS needed to have responsibility for patient safety and quality, and that staff at the sharp end of care have important leadership roles. But they were equally clear that distribution of leadership could go too far, and that retaining a clear focus and priority for patient safety and quality required visible, coherent leadership and an ongoing role for top-level, visionary leadership with positional managerial authority founded in hierarchical structures. Further, they emphasised that clarity and coherence needed to be reproduced at every level of the health service. Thus, from the 'blunt end'[26] of regulation through every level to the sharp end of practice, participants stressed that

staff should not be expected to answer to competing, conflicting, or duplicative requirements or information requests. In this context, the lack of clarity that participants reported about who leads and who should lead quality and safety, which national organisations hold responsibility, and who is accountable and at which organisational levels, is troubling.

The multiple notions of leadership devolution and pluralisation suggest a nuanced, advanced and practically grounded conceptualisation leadership on the part of study participants, showing awareness of the operation of power, hierarchy, medical hegemony, context and systems.[27] Participants mainly avoided giving naïve or simplistic answers about any single, preferred type of leadership. Of particular note in this context are the nuanced examples given of how old and new leadership could best interact to create a culture that both valued quality and safety, and could take the practical action needed to secure improvement.

Thus, though participants acknowledged the benefits and value of distributed leadership, they also suggested that it risked neutralising the focus for getting things done: 'everybody's business becomes 'nobody's business'. They saw interaction between leadership based on (managerial) authority and leadership distributed to individuals as crucial. Sometimes—as in the example given by a senior nurse—a managerial role could be made more 'leaderly' by embracing different styles of direction and instruction that emphasised learning and leading by example. At other times, it was clear that new forms of leadership, involving devolution to distributed leaders who lacked positional authority but possessed contextual knowledge and local credibility needed to be backed up, underwritten and occasionally enforced by old forms of leadership. There was expansive talk about, and considerable

endorsement for, the empowerment of a wide cadre of leaders, especially clinical leaders. Particularly evident was a valuing of managerial-clinical partnerships and shared leadership rather than toleration of historical conflict or division, consistent with analyses identifying that increasing clinical engagement in leadership is an important device for minimising conflict.[8] [17]

Thus, rather than the progressive linear shift implied by notions of 'old' and 'new' leadership, these stakeholders' experiences suggested to them that while distributed, ordinary leadership was vital, so too was tying it into managerial authority and hierarchical infrastructure. Rather than romanticising ordinary leaders[10], leadership of complex systems was seen to require managerial clout and administrative nous.[28, 29] These participants' experiences had, perhaps, sensitised them to the institutional context[10] for leadership, and led to the view that distribution of leadership responsibility, on its own, could have adverse or even perverse unintended consequences. For participants in our study, what was required was an approach to leadership that blended elements of old and new. This suggests that terms 'old' and 'new' in themselves may be perverse, disguising the complexity of the need for the co-existence and exercise of multiple and simultaneous forms of leadership.

This study has a number of limitations. It was based mainly on the accounts of senior level stakeholders and thus had few frontline line or junior representatives and no patients. The study sample used snowballing with its attendant risks of self-selection of 'like-minded' or of highly informed and engaged individuals in the network of respondents. The accounts are time-bounded and collected between January and December 2011, in a time of heightened organisational uncertainty (before the

passage of the new Health and Social Care Act). We have not collected empirical data on leadership performance and have focused only on accounts. Given the focus of our study, we did not collect any data on the leadership training and development backgrounds of our respondents and thus cannot directly trace the influences of formal exposure to leadership models and theories.[30]

The value of our interviews is that they span a diverse set of NHS contexts and different types of NHS organisations. In a system characterised by shifting services, intense reconfiguration of organisations, and movement of key people, questions of who should be doing what kind of leadership, and what helps and hinders, become all the more pressing. With the fast pace of structural reform and redesign occurring in health systems, ensuring that improvement efforts are not damaged by a leadership collapse or dilution is a key goal. The story from this research is that the participants welcome the distribution of leadership but it is not without risks. A clearer national steer—including perhaps a concentration of leadership—and pragmatic local use of a combination of 'old' and 'new' leadership styles are seen as important. Above all, the testimony of these stakeholders shows how the enactment of policy and academic prescriptions for new forms of leadership must be informed by the sophisticated and pragmatic know-how of insiders who are aware of to make them work in organisations that remain permeated by traditional structures, cleavages and power relationships. Such knowledge will have increasing relevance in the search to find the forms of leadership influence that can drive improvement in quality and safety in such an uncertain context.[31]

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